Consent to Health Care Services

I authorize the DuPage Ophthalmology providers to perform any and all forms of diagnostic tests, treatments, medication and therapy. I consent to the doctors employing assistance as he or she deems fit. I authorize the office to contact my emergency contact in case it is necessary.

I consent to the use or disclosure of my medical information by DuPage Ophthalmology for the purpose of diagnosing or providing treatment to me, obtaining payment for my treatment or to conduct healthcare operations of the practice. I understand that treatment by the practice may be denied if I do not sign this consent.

I understand and have been provided with DuPage Ophthalmology *Notice of Privacy Practices.* I understand that I have the right to review the notice prior to signing this consent. DuPage Ophthalmology has the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one when I am in the office.

_____ _____

Signature of Patient or Authorized Representative Date

I understand that **part or all** of the services that I receive during my visit may not be covered by my insurance and I acknowledge that **I am responsible** for the cost of any such services. I understand that my insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants within **45 days** of submission to my insurance company. I am also responsible for all interest, collection, attorney and court fees that will be added to my balance if I fail to pay for these services within the **45 day period**.

An example of a non-covered service is refraction. The cost of glasses refraction is $40 and a complex refraction is $50. Vision care services (routine eye exam, contact lens exam) will not be billed to your health insurance.

_____ _____

Signature of Patient or Authorized Representative Date

I understand that DuPage Ophthalmology providers are **NOT** in network with my insurance company.

_____ _____

Patient or Authorized Representative Date

I understand that DuPage Ophthalmology does **NOT** accept new Medicaid patients at this time. My visit will not be billed to Medicaid.

_____ _____

Signature of Patient or Authorized Representative Date